SCCPM #6 rev. 4.17.23 (English) Follow-up **Date:** _____

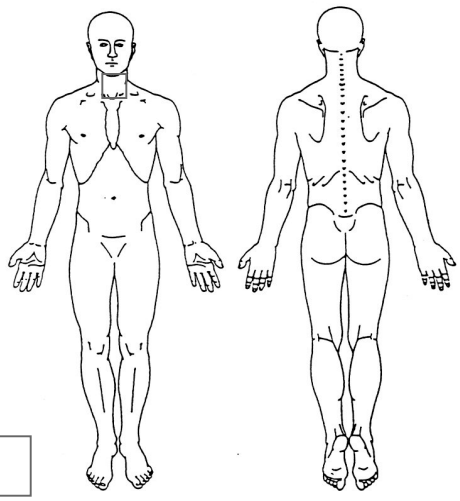
Name: _____ **D.O.B.** _____

Where is your pain? _____

Circle your lowest AND highest pain score daily: **Mark your pain on the diagram.**

0 1 2 3 4 5 6 7 8 9 10 (0 = no pain; 10 = worse pain)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐



How is your pain control? (☐)Better (☐)Good (☐)Fair (☐)Poor

Other: _____ **If better, how much?** _____ %

Physical Therapy has:(☐)Never had PT (☐)helped

(☐)NOT helped (☐)worsened pain (☐)No difference

Medications including anticoagulants: _____

_____

What makes the pain better? (☐)Meds (☐)Injections (☐)Nothing (☐)Other _____

What makes the pain worse? (☐)Daily activities (☐)Walking (☐)Standing (☐)Sitting (☐)Anything

(☐)Using Hands (☐)Head turning (☐)Other: _____

Describe your pain. (☐)Aching (☐)Sharp (☐)Burning (☐)Numbness (☐)Tingling (☐)Weakness; Other:

How is your daily functioning? (☐)Improved (☐)Good (☐)Fair (☐)Poor

How is your mood? (☐)Improved (☐)Good (☐)Fair (☐)Poor

Any side effects from your pain medications? (☐)None; ( )Yes: _____

Any New Test (e.g. MRI, CT, Xrays, blood work), Medical Problems, or Surgeries since your last visit? (☐)No (☐)Yes, What? _____

Review of Systems: Check (√) below all that apply to you. (☐)None (☐)Fever (☐) Weight Loss

(☐)Confusion (☐)Insomnia (☐)Anxiety (☐)Depression (☐)Suicidal thoughts (☐)Itching (☐)Rash

(☐)Poor Appetite (☐)Nausea Other _____

Add'l Comments: _____ **Signature:** _____